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New Zealand's new health sector reforms: back to the future?

Nancy Devlin, Alan Maynard, Nicholas Mays

New Zealand attracted much international attention in the late 1980s and 1990s for its radical economic and social reforms. This reforming tendency shows no signs of abating. In late 1999 the national (conservative) government was replaced by a Labour led coalition, which is rapidly and significantly changing the way publicly financed health services are organised.

Before the general election, Labour had criticised the national government's quasimarket system for its narrow focus on the production of services rather than the improvement of health, for having fragmented a public service, for fostering inappropriate commercial behaviour, for increasing transaction costs, and for lacking local democratic input.¹ These problems were attributed to the "corporate model" of public hospital provision and a single, national purchasing agency. Both will now be replaced with a system promoted as allowing greater community "voice" in health sector decision making and "putting the public back into the public health system."

This paper reviews New Zealand's experience with the quasimarket model and appraises the rationale for another round of structural change. We identify challenges policymakers face in achieving their goals, consider the general lessons provided by New Zealand's frequent U-turns in policy, and offer a set of criteria against which the new system might be assessed.

New Zealand's "experiment with competition"

Throughout the 1980s and early 1990s, dissatisfaction with New Zealand's health system—comprising 14 locally elected area health boards, which both "funded" and provided hospital and some other services in their regions, was rife. Reports pointed to inefficiencies, poor management, budget overruns, and badly eroded assets in public hospitals.² Waiting lists were increasing, and falling public confidence in the system was associated with a growth in private insurance.³ Area health boards were criticised for facing no clear incentives to be efficient or responsive to patients and for weak accountability.⁴

The promarket philosophy of the prevailing government led, in 1993, to an attempt to introduce the perceived advantages of a competitive market into the publicly funded healthcare sector. At the heart of this model was the full separation of purchasing and

Summary points

New Zealand is implementing major changes to the way the health system is organised

The key elements are the development of national strategies and radical restructuring of the healthcare system

The changes reject the current quasimarket approach. Twenty one largely elected district health boards will be responsible for planning most services and delivering hospital services

Challenges facing the new system include the tension between local autonomy and national consistency, avoiding hospital domination designing a defensible formula for allocating funds to district health boards, and ensuring that the reorganisation achieves the government's health goals

Evaluation plays little part in health sector restructuring in New Zealand

A commitment to evaluation in terms of equity, efficiency, and acceptability would improve the accountability of politicians and might avoid frequent, disruptive, and costly U-turns in policy

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providing. It was hoped to increase efficiency, contain expenditure, and reduce waiting lists.⁴ Purchasing was undertaken by four ministerially appointed regional health authorities. Hospitals became publicly owned companies called Crown health enterprises subject to normal company law and required to earn a rate of return on capital comparable to that of a business in the private sector. The original scheme (unlike the NHS model) had been to develop competition not only among providers but also between publicly funded "health plans" for patient enrolments, but this was never implemented.⁵

The disappointing outcomes of this "experiment with competition" provide a sharp contrast with the overoptimistic expectations of its proponents⁶ and are partly a product of difficulties in measurement and substantial lags between cause and effect. Little compe-

tion occurred between providers, especially hospitals.^{3 5} Many Crown health enterprises inherited and continued to report deficits.^{3 5} Barriers to entry limited contestability,⁷ purchasers were conservative and dominated by providers, and barriers to exit (financial support of deficit ridden Crown health enterprises) arguably weakened economic incentives.³ Purchasers and providers struggled to establish contractual relation, transition and transactions costs were high,⁵ and the expected savings were not made.^{5 8}

Thus evidence suggests that the quasimarket model did not achieve obviously greater efficiency. In 1996 a briefing to the incoming minister of Crown health enterprises stated “the health reforms have yet to yield the original expectations. By a range of measures ... the pace of performance seems, if anything, to have weakened since the advent of the reforms.”⁵

There were further concerns. The model emphasised the production of service outputs, with too little attention to the quality of services and their effects on health outcomes. Major inquiries into quality of care and patient safety argued (whether justifiably or not) that the quasimarket model contributed directly to specific instances of poor care.⁹ Further, there was a crucial lack of “buy-in” among both health professionals and the general public. The demoralisation and disempowerment of the health workforce have been attributed to tensions arising from the clash of managerial and clinical cultures.^{10 11}

Some gains did follow the reforms: activity rates continued to increase and average length of stay and unit costs to fall—although whether this was because of, or despite, the changes is a moot point.³ Better information systems facilitated greater accountability and better management of capital.⁵ Māori copurchasers and providers were better able to attract funding to provide more culturally appropriate services.

In 1996, New Zealand’s first proportionally elected coalition government compromised by renaming Crown health enterprises more neutrally as “hospital and health services” and removed their “for profit” status. “Cooperation” replaced “competition” as the new political catch-cry and the regional health authorities were replaced by a single purchaser, the Health Funding Authority.¹² Thus key parts of the market model had already been discarded. The system inherited by the current government bore relatively little resemblance to that originally planned.

Back to the future: the current changes

The current government is winding the clock back still further, returning the system towards its earlier local political origins and away from a “corporate rationalist” model,¹³ by reinstating locally elected boards and abolishing the purchaser-provider split. The changes currently taking place concern two main initiatives (box).

The strategies being developed have been deliberately largely built on existing policies and have attracted little controversy so far. The structural changes, however, represent a radical departure from the current system and have required primary legislation. Its main provisions are outlined in the box. Opinion is divided on the merits of these changes. References to the Treaty of Waitangi in the legislation have

Two principal components of current changes to New Zealand’s health sector

- Structural changes, which replace the current purchaser-provider separation with arrangements to integrate these functions, at least for publicly owned providers and to strengthen local, democratic input to decisions
- Development of national strategies to guide the system; these identify objectives and priorities for improving health and independence levels in the population, aim to reduce the health “gap” between Māori and non-Māori, and specify how services should be delivered

been hotly debated. The Act, however, makes it plain that there is no intention of giving Māori preferential access to services. Rather, the government aims to send a signal to district health boards that it is serious about its intentions to close the health gap between Māori and non-Māori.

Many New Zealanders welcome the return to a familiar public service model. Others have argued that the reforms are “a white elephant trundling back to an inefficient past.”¹⁴ Still others agree with the spirit of the changes but question the need for extensive restructuring to achieve them. Arguably, improved local input—seemingly the central aim of restructuring—could be partly achieved by incremental changes to the current system. Another interpretation is that the changes are largely a “political branding” exercise; or, more positively, that restructuring is needed to signal a clear break with quasimarket approaches.

Challenges facing the new system

The current changes restore a form of local governance very similar to the area health boards that

Main provisions of New Zealand’s new health legislation

- The abolition of the Health Funding Authority
- The transfer of most of the Health Funding Authority’s functions to 21 new district health boards, comprising a majority of locally elected and a minority of ministerially appointed members, accountable to the Minister of Health. District health boards will plan most health and disability support—that is, social care—services (although some services will be funded nationally by the Ministry of Health) and will be responsible for the level, mix, and quality of services and for meeting the health goals, targets, and standards set by the Minister of Health. Public hospitals will be owned and managed by the district health boards
- A minimum of two of the 9-11 board members of the district health board to be Māori
- Mechanisms at the district health board level to enable Māori to contribute to decision making and to participate in the delivery of services so that the principles of the Treaty of Waitangi of 1840 between the Crown and Māori are recognised and respected in the health sector
- The allocation of funding between district health boards according to a formula based on the resident population weighted for relative health need

managed hospital and related services before 1993. That system continued to appeal to those politicians and members of the public who were never reconciled to the quasimarket because it included democratic input, and the area health boards' financial performance was no worse than their successor Crown health enterprises in their early years. But the changes now being planned cannot amount to a simple return to the past. Public expectations are more demanding today, as are requirements for accountability in the public sector. The new arrangements will have to take these factors into account.

The desire for local autonomy in decision making will have to be balanced against national consistency in access to health care (a much cherished goal in New Zealand). Although local representation is a key element of these changes, the government also plans to put in place relatively strict upward accountability arrangements that provide a potentially powerful means for ministers to control the actions of district health boards to secure compliance with national objectives and reasonable consistency in provision. Localism and centralism are never easily reconciled.

It will be important to avoid actual (or perceived) hospital dominance of the new system. For pragmatic reasons the existing infrastructure of hospital management is being used as the initial basis of the district health boards, and the population of each board approximates to the local catchment of its hospital. A coherent approach to planning, funding, and improving access to non-hospital services—particularly primary health care—will be crucial, as this has been the Achilles' heel of the system since its creation in 1938. Government's commitment to developing better primary care¹⁵ and disability support will have to be reflected in the requirements for service development placed on district health boards and monitored accordingly.

The creation of a large number of districts (21, compared with 14 under the area health board system), some with small, dispersed populations, resurrects the challenge of designing a population based formula to allocate resources in a fair and defensible manner. Smaller districts may find it more difficult to manage within their budgets than larger entities; risk management issues will become more visible than with a national purchaser. Twenty one district health boards may not be a sustainable number.

It will also be necessary to keep public expectations within realistic bounds. Some of the early claims on behalf of the changes have been excessively optimistic, just as were the claims for making the health system more business like in the late 1980s. An early presentation on the reforms suggested that "the drive to change the health system comes from gaps between the system's ability to provide and the public perception of need."¹⁶ Economists have long argued that such gaps are unavoidable in a publicly financed system: restructuring cannot remove the rationing problem. Perhaps the best that can be hoped for is that district health boards are perceived as more legitimate rationing agents than the inevitably more remote and technocratic Health Funding Authority.¹⁷

Finally, it will be vital to ensure that the structural changes directly assist in achieving the goals of the health strategies. The risk with a three year electoral

cycle is that putting new institutions in place becomes the end of the process rather than the beginning of a renewed quest for better delivery of services. Yet there are likely to be greater benefits in examining the fundamental questions such as which services should be delivered, in what quantities, and to whom? How can they be provided most cost effectively? And what trade-offs will the public accept between maximising health, distributing the gains according to some notion of fairness, improving responsiveness, and other stated goals? New Zealand has made considerable progress in working towards explicit service prioritisation at a national level.¹⁸ It is uncertain how 21 district health boards will have the capacity to build on this effort.

Alongside the challenges facing the new system, there are some encouraging signs. One is that the pace of change has not prevented extensive consultation on the content of the strategies. Another is that a conscious effort seems to be under way not to lose institutional knowledge and experienced staff during the transition.

Learning from the past

Some important general lessons can be learnt from New Zealand's experience with health sector reform. Firstly, structural change is a tempting way of marking a new ethos, but making new laws may, paradoxically, distract attention from effecting change at the service delivery level. It may take the focus away from other more fundamental issues that are not related to structure, in particular the appraisal of clinical performance and the improvement of implicit and explicit incentive mechanisms.

Secondly, restructuring takes time to do, to "bed down" and to deliver results—it may not be evident for some time what has occurred and even then the "counterfactual" (what would the outcomes have been under the old regime?) remains unknown.

Continual restructuring is costly and disruptive. Notwithstanding the difficulties involved in comparative assessment, in New Zealand, as elsewhere, a greater commitment to policy evaluation is required. Restruc-



A familiar public services model: New Zealand's new district health boards will both plan healthcare and deliver hospital services

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turing proposals should be accompanied by clearly stated, measurable objectives against which the new system's performance can be monitored and scrutinised. Proposals for change should also be accompanied by estimates of the transitional and ongoing costs to be incurred in pursuit of its benefits.

Commitment to the routine measurement and publication of key indicators of the performance of the health system would also greatly improve the ability of politicians to justify and be held accountable for structural change and of the public to engage in informed debate. A template for such assessments could include, for example: indicators of the technical efficiency of providers, transactions costs as a proportion of total spending, horizontal equity (the extent to which those with similar levels of need receive similar services), reductions in levels of ill health and of health inequality attributable to health services, and users' experiences of services.

New Zealand's health sector is headed back to the future. Whether that future holds the solutions to New Zealanders' health aspirations is unclear. A commitment to rigorous evaluation of the current social experiment is required to determine whether the future is better than the past.

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Appraising organised screening programmes for testing for genetic susceptibility to cancer

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Public health officials rely on criteria developed by Wilson and Jungner for assessing whether or not to implement population screening programmes. These criteria were developed over 30 years ago, when screening primarily focused on detecting early stages or precursors of chronic disease. With the introduction of testing for genetic susceptibility, particularly for cancer, it is important to assess whether these criteria can continue to be applied in the decision making process. We report on a workshop that assessed criteria for population screening in the context of testing for genetic susceptibility to cancer.

Many criteria for the evaluation of screening programmes have been proposed,^{1,2} and most are similar to those proposed by Wilson and Jungner in a 1968 World Health Organization report.³ The criteria are based on a simple linear model of disease progression (figure) in which screening tests primarily detect a preclinical asymptomatic phase.

The continuum of screening has expanded to include a range of other states. The figure illustrates another model for screening—screening for risk factors or susceptibility, the detection of risk factors for disease⁴ (such as blood pressure or cholesterol concen-

Summary points

Screening has expanded from early detection of disease or its precursors to include testing for susceptibility, such as genetic testing for cancer

The Wilson and Jungner framework for evaluating screening tests, produced for the World Health Organization in 1968, is commonly used for population screening

The relevance of this framework for testing for genetic susceptibility to cancer has not previously been assessed

A modified Wilson and Jungner framework can continue to provide a robust approach to evaluating testing for genetic susceptibility

tration), or the identification, through the detection of genetic markers, of individuals who have increased susceptibility to disease.⁵ Separate consideration of

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Details of the workshop participants can be found on the BMJ's website